STUDY PROJECT

MEDICAL COMMAND IN THE CONTINGENCY FORCE

BY

Lieutenant Colonel Ira F. Walton, III
United States Army

USAWC CLASS OF 1992

U.S. ARMY WAR COLLEGE, CARLISLE BARRACKS, PA 17013-5050

UNCLASSIFIED
SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION UNCLASSIFIED	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY	3. DISTRIBUTION / AVAILABILITY OF REPORT Approved for public release. Distribution is unlimited.
2b. DECLASSIFICATION / DOWNGRADING SCHEDULE	
4. PERFORMING ORGANIZATION REPORT NUMBER(S)	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION U.S. ARMY WAR COLLEGE 6b. OFFICE SYMBOL (If applicable)	7a. NAME OF MONITORING ORGANIZATION
6c. ADDRESS (City, State, and ZIP Code) ROOT HALL, BUILDING 122 CARLISLE, PA 17013-5050	7b. ADDRESS (City, State, and ZIP Code)
8a. NAME OF FUNDING / SPONSORING ORGANIZATION 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. / PROJECT NO. / TASK NO. / WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)

Medical Command in the Contingency Force

12. PERSONAL AUTHOR(S)
LTC Ira F. Walton III

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Study Project	FROM _____ TO _____	92/04/15	31

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

Desert Shield/Storm accelerated the identification of an organizational weakness in the command and control of the medical component of the XVIII Airborne Corps. On 20 December 1991, the XVIII Airborne Commander approved a reorganization plan which removed the 44th Medical Brigade from 1st COSCOM, establishing the 44th Medical Brigade as a separate brigade. This paper will explain why this change was needed in the Corps and analyze the organizational change using accepted management principles. The conclusion suggests that the medical command and control organizational doctrine for the Army at the corps level may need to be modified to obtain some of the advantages of this organizational structure change.

20. DISTRIBUTION / AVAILABILITY OF ABSTRACT ☐ UNCLASSIFIED/UNLIMITED ☒ SAME AS RPT ☐ DTIC USERS	21. ABSTRACT SECURITY CLASSIFICATION UNCLASSIFIED
22a. NAME OF RESPONSIBLE INDIVIDUAL COL Lorna E. Strzelecki, Project Adviser	22b. TELEPHONE (Include Area Code) 717/245-3677 / 22c. OFFICE SYMBOL AWCAA

DD Form 1473, JUN 86 Previous editions are obsolete SECURITY CLASSIFICATION OF THIS PAGE

USAWC MILITARY STUDIES PROGRAM PAPER

MEDICAL COMMAND IN THE CONTINGENCY FORCE

AN INDIVIDUAL STUDY PROJECT

by

Lieutenant Colonel Ira F. Walton III
United States Army

Colonel Lorna Strzelecki
Project Advisor

U.S. Army College
Carlisle Barracks, Pennsylvania 17013

ABSTRACT

AUTHOR: Ira F. Walton III, Lt Col, USA

TITLE: MEDICAL COMMAND IN THE CONTINGENCY FORCE

FORMAT: Individual Study Project

DATE: 15 April 1992 PAGES: 25 CLASSIFICATION: Unclassified

Desert Shield/Storm accelerated the identification of an organizational weakness in the command and control of the medical component of the XVIII Airborne Corps. On 20 December 1991, the XVIII Airborne Commander, approved a reorganization plan which removed the 44th Medical Brigade from 1st COSCOM establishing the 44th Medical Brigade as a separate brigade. This paper will explain why this change was needed in the Corps and analyze the organizational change using accepted management principles. The conclusion suggests that the medical command and control organizational doctrine for the Army at the corps level may need to be modified to obtain some of the advantages of this organizational structure change.

MEDICAL COMMAND IN THE CONTINGENCY FORCE

In 1974, the 44th Medical Brigade was reactivated as part of the XVIII ABN Corps to provide command and control of corps level medical units stationed at Fort Bragg, North Carolina. It was decided that during peacetime the Brigade would be under the command and control of 1st COSCOM with a Medical Service Corps (MSC) colonel as commander. When the Corps fully deployed, however, the 44th would become a separate brigade with a Medical Corps brigadier general replacing the MSC colonel as commander.

Since that time individual units or slices of the Brigade have participated in the military interventions in Grenada and Panama. Also during this period units were assigned to provide emergency humanitarian efforts such as the Cuban refugee problem and the Hurricane Hugo disaster on the island of St. Croix, Virgin Islands. None of these efforts required the full deployment of the Brigade or the assignment of its authorized general officer commander.[1] In 1985 doctrinal revision placed the 44th permanently under the command and control of the 1st COSCOM, even during deployment. Thus, when the Corps and 1st COSCOM deployed to Desert Shield/Storm the 44th went as a subordinate unit of the 1st COSCOM.

The downsizing of the Army and the increase of the importance and capability of the XVIII ABN Corps under the Chairman of the Joint Chiefs of Staff's base force concept, coupled with the Army Medical Department's (AMEDD) after action review of Desert Storm

has caused an evolution in the role (what) and purpose (why) of the 44th Medical Brigade. The 44th's role is expanding to include command and control of all medical units assigned to the Corps during peace time regardless of whether or not they are located on Fort Bragg. The purpose is returning to the pre-1985 doctrine where the Brigade is directly responsible to the Corps for medical matters eliminating the 1st COSCOM from the chain of command.[2] To facilitate the increased importance of the Corps and to establish the proper clinical readiness identified as a shortcoming during Desert Storm, a Medical Corps brigadier general will assume command of the 44th Medical Brigade during peacetime.

The purpose of this paper is to provide a historical review of the medical brigade's command evolution and an analysis of the proposed command structure. The paper will show how Desert Shield/Storm accelerated the identification of a weakness in the command and control of the medical component of the XVIII Airborne Corps. This is followed by a layout of current and future organizational doctrine. A discussion is presented explaining why the change is consistent with current accepted management parameters. Using management principles, this discussion will also demonstrate the advantages and disadvantages of the decision, recognizing that no organization structure is perfect. The conclusion postulates on the impact this change has on the Army's medical command and control doctrine.

DESERT SHIELD/STORM EXPERIENCES

Prior to Desert Shield/Storm the Brigade was composed of a medical supply and maintenance battalion (MEDSOM); a mobile army surgical hospital (MASH); a combat support hospital (CSH); and a separate medical battalion with ground and air evacuation, a medical clearing company, and surgical, veterinary, and preventive medicine detachments. With the exception of a few nurses assigned to the two hospitals, the professional clinical staff was designated through the professional officer filler system (PROFIS) to be activated only upon deployment.

The PROFIS program is the way the AMEDD designates a person not assigned to a field medical unit to fill an authorized position when deployed. The program was originally designed to demonstrate there were sufficient people with the required skills on active duty to meet mobilization needs. The actual assignments are made at all levels of the process using available resources to fill required positions and forwarding unfilled needs and excess resources to the next higher headquarters. Conceptually the system is not designed as a training resource roster and the assignments are made under the assumption that time will be available to review the assignments prior to an actual deployment. The Office of the Surgeon General has final responsibility for compiling the data provided by U.S. Army Health Services Command, 7th Medical Command and 18th Medical Command and publishing a document that places names against authorized spaces.

The PROFIS program is also responsible for providing Medical Corps commanders to replace the peacetime Medical Service Corps commanders of hospitals. The 44th is allocated a Medical Corps brigadier general commander to be identified at time of deployment.[3]

Even though the 44th provided support to the XVIII ABN Corps, who has a very rapid response mission, the standard PROFIS program, based on the concept that sufficient time would be available to sort out clinical staffing prior to a complete deployment, remained in place. Operation Just Cause was carried out with a very small, pre-selected clinical staff who trained year round with specially designed surgical teams that made up that unique medical package.[4] The medical success during Operation Just Cause incorrectly reenforced the PROFIS planning concept for the rest of the Army. When Desert Shield/Storm was executed on a come-as-you-are basis the fallacy in the planning concept became apparent. A come-as-you-are deployment means that there is insufficient time to review pre-planned staffing and equipment prior to departing. Any errors are to be sorted out after deployment.

Since the PROFIS designated commanders are not processed through the normal command selection process, some individuals are placed in command positions who do not meet the established criteria for being a commander. As a result, during Desert Shield/Storm, commanders for two different hospitals who were not prepared for command were relieved within 30 days of assuming

command. It is important to note that no current MEDDAC commanders were sent to command any hospital or unit deployed to Desert Shield/Storm.[5] In another instance the PROFIS commander for a surgical hospital, which calls for a surgeon, was a family practitioner. However, he had deployed with the unit six months earlier on REFORGER 90; so, despite the specialty mismatch, his previous experience and a strong deputy commander made this one of the more successful units in the brigade.

The PROFIS assignments for all the medical units identified for deployment were adjusted as time permitted.[6] The need for adjustments was documented by the post operation General Accounting Office medical study which reported that only 449 of the 778 individuals identified by PROFIS actually deployed with their assigned unit.[7] The PROFIS fillers for Fort Bragg units had a much higher percentage of compliance because history had shown that they would probably have to be actually used to deploy.[8]

In retrospect it appears that the clinical assignments after the initial rush were made with the belief that the deploying forces were only a show of force and combat was not going to occur. As additional proof that the system did not allow for special attention to medical command needs, a brigadier general to command the 44th Medical Brigade was not made available until late November. By this time most of the organization was in place; and, with President Bush threatening to initiate combat within six weeks, the Corps commander declined the nominee.[9]

During the deployment to Desert Shield the 44th Medical Brigade Headquarters found that it had to be in two places at one time. Every ten days a new medical plan was written to provide medical support to the troops preparing to be attacked in Saudi Arabia. Furthermore, extensive preparations were required to receive incoming medical units in a very hostile resource-scarce environment. At the same time, decisions still needed to be made concerning which units to deploy, at what interval and by what means of transport. This was a problem that had a doctrinal solution. The doctrinal solution was to deploy a medical group early with the mission to prepare for and receive incoming units while the brigade completed the deployment package.

The solution, however, was not implementable because no medical group was assigned to the XVIII ABN Corps. The Brigade was forced to split its forces creating unnecessary challenges in both places.[10] The first medical group did not close in country until early November. The only fully functional medical command elements in country as late as the end of October were part of the 44th Brigade Headquarters and one medical battalion. At one point this medical battalion had fifteen subordinate units and the Brigade had an additional twelve.[11] If Iraq had attacked during this period this situation would have created a medical command crisis. The new structural change adds a medical group to the 44th at Fort Bragg which will eliminate this problem in the future.

The 44th Medical Brigade was completely assembled in Saudi Arabia by mid-December. It started Desert Storm with an almost complete doctrinally structured brigade consisting of two groups, four medical battalions, five evacuation hospitals, three MASHs, four CSHs, one MEDSOM, a dental company, and a sufficient number of specialized detachments. Except for establishing a forward and rear medical group alignment rather than a side by side medical group alignment, it was fully deployed on the day the war started in keeping with current medical doctrine.

Problems identified in the after action review included inadequate communications equipment; extreme shortage of transportation assets to move hospitals that were never authorized trucks for self movement; and poor information collection from higher headquarters concerning troop locations and aviation data. Despite the fog of war problems, the after action review of the medical brigade's performance was exceptionally positive in relation to supporting the Corps during the historic advance into and subsequent withdrawal from Iraq.[12]

After several layers of after action reviews, the common theme was that the cost of success in terms of unprogrammed energy and resources was too high. To continue to depend on having essentially four months to build up medical support; using untested and unscreened medical commanders; and operating the brigade headquarters in two locations at one time would be too risky for the XVIII ABN Corps in the future. Therefore, the Corps Surgeon set out with the guidance and support of the Corps

Deputy Commanding General to create an organization that could meet the demands of the XVIII ABN Corps in the future.

The best solution identified was to change the organization and set up a separate medical brigade that would be responsible for all Corps medical units commanded by a Medical Corps brigadier general. A major obstacle was overcome when the Surgeon General of the Army agreed to allow the general officer scheduled for assignment to command Fort Bragg's new medical center to become the 44th Medical Brigade commander. This agreement was conditional on the Corps Commander's concurrence. Taking advantage of this unique opportunity, the staffs at Forces Command, Office of the Surgeon General, and the XVIII ABN Corps created a plan to implement a reorganization which would make the medical brigade separate from 1st COSCOM and create a subordinate medical group at Fort Bragg.[13]

ORGANIZATION DOCTRINE

Figures 1 through 3 with narrative descriptions show the current doctrine for organizational structure of a medical brigade, corps support command and a corps. The issue is whether the command and control relationship between the Medical Brigade and the 1st COSCOM and the Corps is best for the XVIII ABN Corps. The XXs placed above some organization blocks designate the number of stars the general officer commanding that organization is authorized.

Under MED FORCE 2000, the medical support doctrinally aligned to a five division corps is as follows: one medical brigade, two medical groups, one medical battalion logistics (fwd), and one veterinary headquarters detachment. Each medical group consists of one evacuation battalion, one mobile surgical hospital (MASH), one area support medical battalion (ASMB), six combat support hospitals (CSH), one dental battalion, one combat stress company (CSC) and various medical detachments according to need and geographic location.[14] Figure 1 depicts the command relationship for a doctrinal medical brigade. This complete organization is assigned to the corps support command (COSCOM) for command and control.[15]

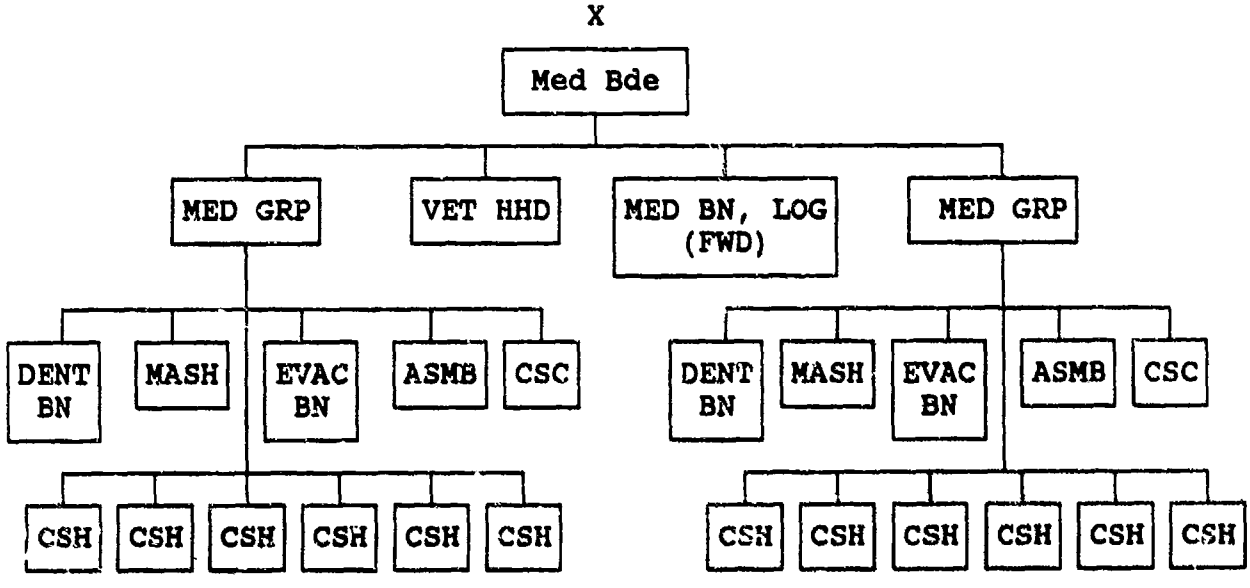


Figure 1

As shown in figure 2 current CSS structural concept for a generic corps support command is one support group per division supported and one main support group for the corps rear, a corps material management center, a movement center, and the medical brigade.[16] Interesting to note that the personnel and finance groups assigned to the COSCOM in the 1985 doctrine have migrated out of COSCOM and are now organized directly under the Corps as depicted in figure 3. This is germane in that when determining which primary staff section is responsible for planning medical support, many consider it more related to the personnel function (which is now no longer part of COSCOM), than to logistics.

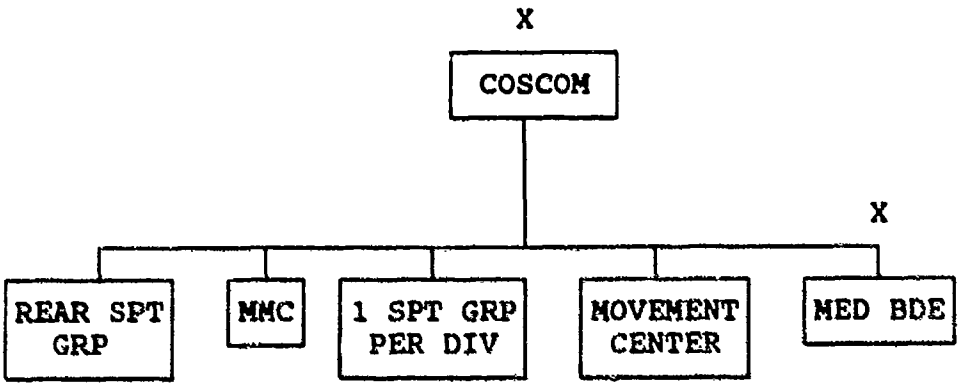


Figure 2

The Corps structure displayed in figure 3 is designed around its mission with the number of divisions and size of corps support units varying accordingly. The XVIII ABN Corps is currently organized with the following major units; five

divisions, a headquarters brigade, signal brigade, an aviation brigade, an engineer brigade, a military police brigade, a personnel group, a military intelligence brigade, a finance group, a corps artillery command, and a corps support command.[17] Comparing Figure 2 and 3 shows that the medical brigade is the only organization commanded by a general officer in the Corps which does not report directly to the Corps Headquarters.

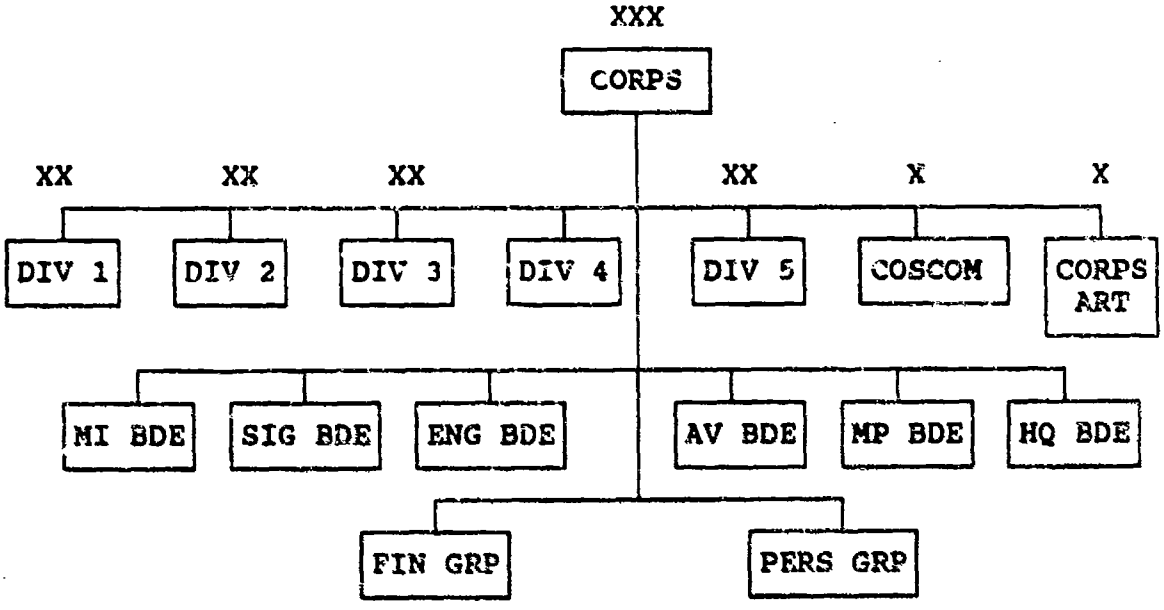


Figure 3

MANAGEMENT DISCUSSION

Most management experts on organizational structure will agree that there is no such thing as an ideal organizational structure or that any organizational structure is ever entirely

rational.[18] One of the most overlooked principles in constructing an organization is that the structure must not only facilitate performance but must also cater to the needs of the individuals and groups that work within the designated structure.[19] Given these basic principles, it is very important to understand that before changing an organization's structure three management axioms on change must be considered.

First, change is not based on how well the organization is doing its assigned role; because, it may be doing the wrong role very well. Secondly, change should be based on whether or not the organization should be doing the assigned role. The final axiom is that change should be undertaken regardless of the first two if the existing structure is untenable in the foreseeable circumstances in which the organization must operate.[20]

As previously described, the 44th was extremely successful in Desert Shield/Storm because the initial problems with the strength of key clinical leaders and communication shortfalls were worked through or around. While the formal (organizational structure) relationship with 1st COSCOM was being questioned at the Brigade level, the relationship on a personal basis remained positive.[21] Leaders at all levels had taken the steps necessary to make both COSCOM and the 44th capable of completing the assigned mission. Therefore, the proposed organization change was in compliance with the first axiom. The attempt to make an organizational change was not being based on current performance.

The second axiom used to evaluate whether organization change should be undertaken is whether or not the organization should be doing its assigned role. The following discussion examines the proposed change's impact on the role of the three organizations involved: the Brigade, COSCOM, and the Corps Headquarters. This discussion will show that the change, as described, is clearly an outcome of role examination.

The Brigade's role was limited to the medical units at Fort Bragg. Those XVIII ABN Corps medical units located at other corps installations did not have any tie to the Medical Brigade during peacetime. This created a situation where medical readiness at the battalion and hospital level on other installations was being supervised by non-medical supervisors because there were no higher level medical command units available at each installation.[22] The Brigade did not have a solid role in the clinical PROFIS assignments nor did it or the Corps Surgeon's office possess any clout to effect quality control on the assignment process. While these shortcomings reflected negatively on the overall Corps performance they did not reflect on the peacetime performance of the Brigade since they were not part of the assigned peacetime role. The conclusion was that the overall role assigned to the brigade during peacetime was limited and below its doctrinal level of purpose.[23]

The need for 1st COSCOM to perform the role of command and control of the Brigade was examined to determine if it was appropriate. The original assignment of the Brigade to 1st COSCOM was based on three concepts: the span of control of the Corps was too large; medical service is a combat service support function and medical units should be commanded by the CSS headquarters[24]; and the medical community believed that they could receive better support if they were a member of COSCOM as opposed to a COSCOM customer.[25] Close examination of the role COSCOM provided in this context revealed that COSCOM did not have to perform this role.

According to the Corps Deputy Commanding General adding the Medical Brigade to the Corps' span of control was not a problem. This opinion was based on the idea that a unit commanded by a general officer was essentially self manageable and that the Corps had more available expertise than COSCOM to add value to the Brigade's performance.[26] While medical support was classified as a combat service support (CSS) function, the CSS role of a COSCOM (as was determined for finance and personnel) was not interrelated with the medical CSS mission.[27] As identified in the COSCOM organization doctrine review (Figures 2 & 3), many contended that medical support was more closely related to the personnel function than the logistics function.

COSCOM was, and still is, responsible for providing equipment to the Medical Brigade because resources requested for medical

units in the Army planning, programming, budgeting and execution system (PPBES) process were with the understanding that COSCOM would provide them.[28] The 1st COSCOM commander during Desert Shield/Storm stated that he had made sacrifices to support the Medical Brigade with COSCOM equipment in accordance with the resource agreement. He would not have voluntarily done this if the 44th had not been part of his command responsibility.[29] The question to be answered in the future is whether COSCOM commanders will continue to support fully the medical community even if it does take sacrifices.

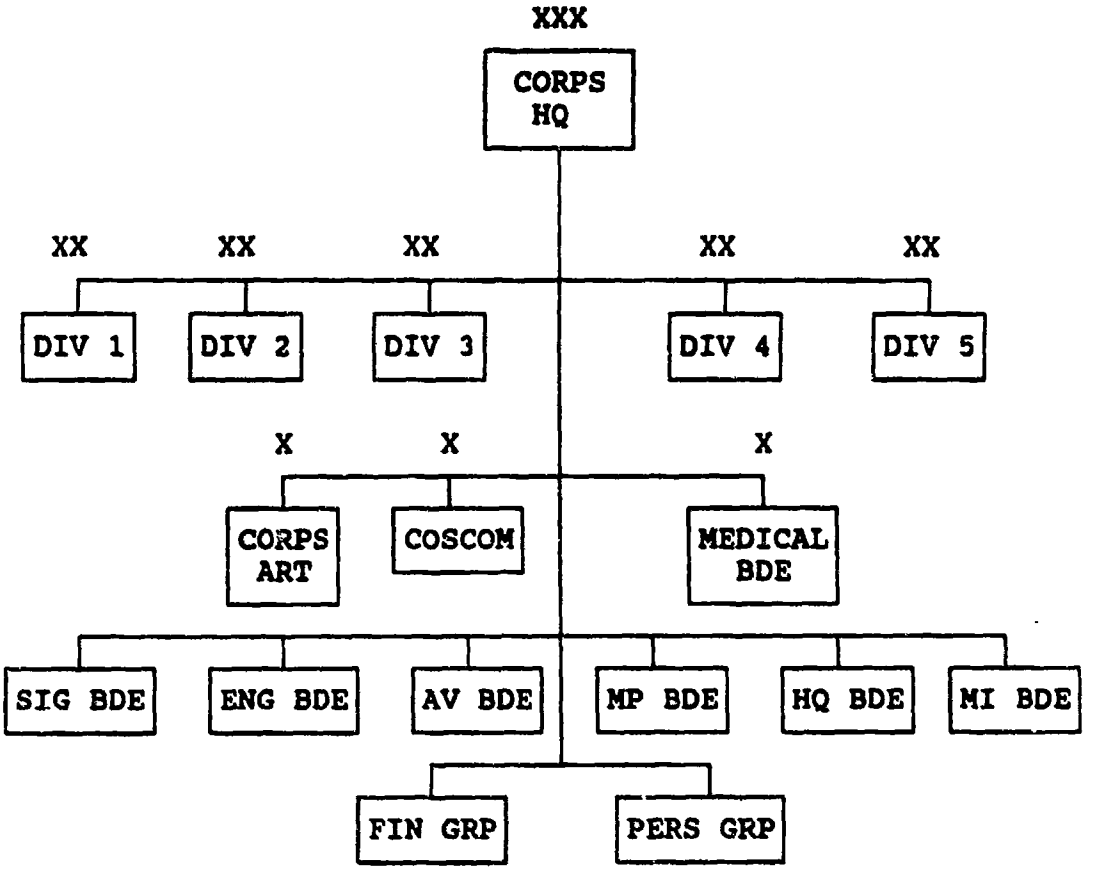
From a Corps perspective, the 1st COSCOM was assigned a role and mission that was more appropriately the Corps Commander's. In effect the COSCOM was given responsibility for the health of the command. Therefore, the Corps Commander depends on the Corps Surgeon to monitor this valuable function and if problems develop he holds the COSCOM commander responsible.[30] However, the COSCOM commander has only a small medical advisory staff which is authorized as part of the Medical Brigade, not COSCOM, to exercise his responsibility.[31] Many management theorists would conclude that this is responsibility without proper expert authority.

The last hurdle in the decision matrix is whether or not the existing organization structure is untenable in the expected future environment in which it must operate. Current predictions are that the XVIII ABN Corps must be able to deploy as a corps on

very short notice to resolve a regional conflict anywhere in the world. The previous build up time and a gradual deployment schedule can no longer be considered as a planning factor. The medical organization responsible for XVIII ABN Corps' medical support must be able to deploy in a no-notice situation; coordinate and integrate medical units located throughout the Corps and the Army in the deployment package; provide the Corps competent, fully-staffed medical units capable of providing quality care on the first day of arrival; and insure a qualified command structure exists to support the deployed medical units.[32] The current structure of the Medical Brigade does not allow this to be accomplished in an effective and efficient manner; therefore, the current structure is untenable in the foreseeable future.[33]

Given this conclusion, the only remaining step is to determine what organization command structure will best serve the XVIII ABN Corps Corps' medical assets in the future. The organizational chart shown in Figure 4 depicts the Medical Brigade's relationship to the other separate commands in accordance with the XVIII ABN Corps commander's decision.[34]

Figure 5 shows how the 44th Medical Brigade's structure changes to add Corps medical units not stationed on Fort Bragg; and also adds a subordinate medical group.[35]



(Garrison and other peacetime corps units are deleted)

Figure 4

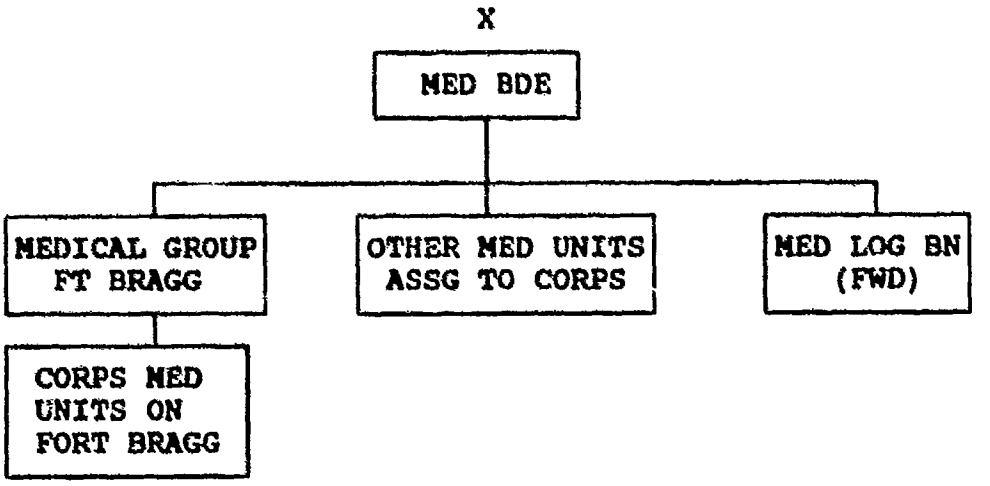


Figure 5

ADVANTAGES

The biggest advantage to the XVIII Airborne Corps is that this creates a medical command organization that will be more likely to meet the role identified for it within the Corps in the future.[36] In addition, by making this commitment the Corps has obtained resources now dedicated to improving medical readiness that otherwise may not have been made available. Specifically, the assignment of a Medical Corps general officer brings more benefits, such as greater clinical staff interest in combat medicine, not realized with a Medical Service Corps brigade commander.[37]

Currently, the career path leading to promotion to general officer in the Medical Corps is not related to field units and combat medicine type assignments. Now, with a Medical Corps general in the XVIII ABN Corps, a physician will find it advantageous to add to his resume the command of a TO&E hospital.[38] MEDDAC commanders will know that someone with potential impact on their next promotion is reviewing the clinical staff designated as PROFIS to the Corps' hospitals.[39] With the decreasing emphasis on Europe and the increased importance of the XVIII ABN Corps it is easy to predict that this command position will become very influential.[40]

Another advantage to this restructuring is that the Corps receives a medical group as an additional command headquarters element.[41] Now, with the separation from 1st COSCOM, the Brigade can rightfully claim that it adds value to the

supervision process for Corps medical units located on and off Fort Bragg.[42] Prior to this, other installations could always claim that their CSS commander or garrison commander could do as good a job as non-medical commanders at COSCOM. This argument is no longer valid and, in return, organizational readiness should be improved.[43] The establishment of the medical group gives the Corps a rapidly deployable senior medical headquarters element to prevent the problem identified during Desert Shield where the Brigade had to function in two locations at one time. The new organizational structure will provide the opportunity to more easily assume the enhanced demanding role required to support the new XVIII ABN Corps.[44]

The new separate brigade organization, with its Medical Corps general officer, as commander caters to the needs of the individuals and groups that make up the Brigade better than the old did under 1st COSCOM. A senior level role model with clinical as well as leadership credibility is now available who is dedicated to the preparation of preserving life in time of war. This was not possible in the old system.[45] The past Brigade commanders were in reality caretakers scheduled to step aside for a Medical Corps general officer in time of war. Neither these MSC commanders nor the COSCOM commanders could be complete role models for young physicians.[46]

The senior staff officers at the Brigade were normally senior majors or junior lieutenant colonels and rarely filled by ex-battalion commanders. Under the new organization, these

officers will be senior lieutenant colonels who most likely will have served as battalion commanders. The chief of staff will be a colonel who has probably just completed command.[47] Clearly the level of expertise and sophistication will rise due to organization structure. This enhanced environment will better meet the needs and aspirations of its members, as well as provide a much broader support base for the assigned units.

The 1st COSCOM benefits from the new organization because its span of control is reduced. During Desert Shield/Storm the 1st COSCOM grew to over 24,000 troops with a third of them being medical personnel. During this period, they only had one medical staff officer, a MSC major. The impact is that the unit with which COSCOM had the least expertise and, therefore, the most anxiety will no longer be a part of its mission. In management terms, its multi-functional purpose has been streamlined and is no longer cluttered with a completely dissimilar unit. In military terms, it is no longer responsible for the health of the command which is a mission they were never trained or resourced to assume. That responsibility is now rightfully returned to the Corps commander.[48]

The final advantages gained are those associated with the generic characteristics of a product-driven organizational structure (medical) as compared to a multi-functional organizational structure (COSCOM). The advantages of a product-driven organization are: the product becomes the central focus; decision making tends to be faster and more effective;

responsibilities are more clearly defined; performance is more easily assessed; and the overall organization is better suited to function in a dynamic environment.[49] This last advantage is most important when your role is to operate in a combat environment.

DISADVANTAGES

Accepting the concept that there is no ideal organizational structure for any given purpose, the following disadvantages are identified as inherent in this new organization. They are identified to insure management is sensitive to the new structure's potential shortcomings. Once recognized, it will take the appropriate amount of extra time and effort to keep any one or combination of these issues from becoming obstacles to the organization's success.

The Army Medical Department (AMEDD) will lose the full time services to peacetime patient care of one of its few general officers. Under the new agreement, the medical general officer at Fort Bragg will be dual hatted as the Brigade Commander and the Director of Health Services for Fort Bragg. As the Director of Health Services he will supervise the medical corps colonel in command of the medical center.[50]

The U.S. Army Logistics Center has been a strong ally of the medical community on resource issues in the combat zone. Part of this support was based on the fact that if the medical units were part of the logistics family then support for medical resources in the combat zone was support for the logistical function. Now

that the medical units are not part of COSCOM, this sets up a situation where the logistical function and the medical function will be competing against each other for resources in the PPBES process.[31] In the past, PPBES compromises on resource purchases of medical transportation and general support equipment were reduced based on agreements that the COSCOM would provide the resources as needed. This agreement was partially guaranteed because it was part of the COSCOM mission so there was really no other choice. The separation of the Brigade from COSCOM takes away the agreement guarantee.

From the Corps Headquarters perspective, the new structure will create a few new problems. First, the headquarters increases its immediate span of control with the Deputy Corps Commanding General assuming the additional responsibility for supervising the Medical Brigade. The organization trauma to people and systems created by the change in COSCOM, the Brigade, and Corps Headquarters will cause temporary inefficiencies during the reorganization period. The Corps will also have to absorb the higher costs of housing and maintaining an additional command organization on Fort Bragg.[32] This system will again make the XVIII ABN Corps different from the other corps in the Army; and being different can cause intangible costs from jealously to staffing confusion.

The Medical Brigade and the Medical Group will have to work harder to coordinate combat service support services from COSCOM. Staff familiarity with medical-unique requirements will fade with

personnel rotations. It will clearly be Brigade and Group responsibilities to insure resource needs are prepositioned early on in COSCOM's decision and planning cycle.[53]

CONCLUSION

Applying this structural change in the medical command and control for the XVIII ABN Corps to doctrine for the rest of the Army is not a clear-cut endeavor. There is only one medical brigade in the active duty structure, therefore, the other corps will not have a medical brigade available.[54] At present no other corps has a no-notice mission to deploy so there is sufficient time to be clinically fleshed out after notice of an impending deployment. The three remaining corps in the base force are authorized a medical group as the medical command and control headquarters. The current role and mission of a medical group is administrative, therefore, the Medical Service Corps colonel authorized by doctrine to command a medical group is properly suited for the mission. The actions taken by the XVIII ABN Corps indicate that serious consideration should be given to changing the alignment of the medical brigade once deployed to the theater. Additional studies are needed to determine if the medical and combat service support doctrine should be modified, as it has been with personnel and finance, to remove the medical forces from CSS organizations in echelons above divisions.

This bold, innovative decision is without parallel in modern military medical history. The outcome certainly supports the premise that structure decisions are better if based on the role and purpose of the organization in concert with the needs of the individuals and groups that will make up the proposed unit. One cannot lose sight of the vision and willingness to act on the part of the Army's Surgeon General and the Deputy Corps Commander to be able to propose and implement this change. LTG Luck, the XVIII ABN Corps Commander, made a dynamic decision that will have positive effect on the medical care available to his troops and which may never be fully appreciated until the after action review of the next Corps deployment to war.

ENDNOTES

1. Interview with Ray J. Terrill, LTC, U.S. Army, Ft. Bragg, NC, 6 November and 9, 17, 30 December 1991.

2. Interview with Harold L. Timboe, COL, U.S. Army, Ft. Bragg, NC, 6 December 1991.

3. Terrill, interview.

4. Interviews with Jerome V. Foust, COL, U.S. Army, Ft. Sam Houston, TX, 14 November and 9 December 1991, and 10 February 1992.

5. Interviews with Robert J. Poux, LTC, U.S. Army, Washington, DC, 16 December 1991 and 3-5 February 1992.

6. Interviews with George S. Robinson, LTC, U.S. Army, Carlisle, PA, 7-8 November 1991 and 3-5 February 1992.

7. U.S. General Accounting Office, Operation Desert Storm: Full Army Medical Capability Not Achieved, p. 5.

8. Robinson, interview.

9. Foust, interview.

10. Robinson, interview.

11. Forty-Fourth Medical Brigade, Desert Shield/Desert Storm After Action Report, 5 May 1991, chapter 14, section 2.

12. Ibid., chapter 14, summary.

13. Timboe, interview.

14. U.S. Department of the Army, Field Manual 8-10, Appendix A.

15. U.S. Department of the Army, Field Manual 63-3J, p. 3-2 (hereafter referred to as "FM 63-3J").

16. U.S. Department of the Army, Field Manual 63-3, pp.3-19 (hereafter referred to as "FM 63-3").

17. Interviews with Michael Garrett, MAJ, U.S. Army, 6, 9, 23 December 1991 and 21 January 1992.

18. Saul W. Gelleman, "In Organizations, as in Architecture, Form Follows Function," Organizational Dynamics, Winter 1990, p. 61.

19. Ibid., p. 57.

20. Ibid., p. 68.

21. Foust, interview.

22. Harold L. Timboe, COL, Establishing Separate Medical Brigade, Decision briefing to Commander, XVIII ABN Corps, Ft. Bragg, NC, 20 December 1991.

23. Foust, interview.

24. FM-63-3, pp. 3-6.

25. Interview with Samuel A. Brown, COL, U.S. Army, Ft. Bragg, NC, 17 October 1991.

26. Timboe, Decision briefing.

27. FM 63-3J, pp. 3-6, 3-8, 3-13.

28. Interview with John G. Zierdt, BG, U.S. Army, Atlanta, GA, 20 December 1991.

29. Zierdt, interview.

30. Timboe, Decision briefing.

31. FM 63-3J, p. 3-15.

32. Terrill, interview.

33. Timboe, interview.

34. Garrett, interview.

35. Timboe, Decision briefing.

36. Foust, interview.

37. Interviews with Michael J. Kussman, Carlisle, PA, 10 December 1991 and 5 February 1992.

38. Timboe, interview.

39. Kussman, interview.

40. Ibid.

41. Interview with Frank G. McDonald, LTC, U.S. Army, Atlanta, GA, 3 January 1992.

42. Timboe, interview.

43. Foust, interview.

44. Timboe, interview.

45. Foust, interview.

46. Ibid.

47. Interview with Robert B. Romines, COL, U.S. Army, Alexandria, VA, 10 February 1992.

48. Foust, interview.

49. John A. Pearce II and Richard B. Robinson, Jr., Chapter 10: "Fundamentals of Organizing," Management, 1989, p. 312.

50. Timboe, interview.

51. Brown, interview.

52. Garrett, interview.

53. Terrill, interview.

54. McDonald, interview.

BIBLIOGRAPHY

Black, Charles M., LTC. Leadership at the Operational Level. Carlisle Barracks, PA: U.S. Army War College, 17 March 1988.

Blair, Hal R., LTC, Chief of Staff, 44th Medical Brigade. Interview by author, 6 December 1991, Ft. Bragg, NC.

Brown, Samuel A., COL, Director of Doctrine and Training, Academy of Health Sciences. Interview by author, 17 October 1991, Ft. Sam Houston, TX.

Forty-Fourth Medical Brigade. Desert Shield/Desert Storm After Action Report. Ft. Bragg, NC: 5 May 1991.

Foust, Jerome V., COL, Commander, 44th Medical Brigade, 1989-91. Interviews by author, 14 November and 9 December 1991, and 10 February 1992, Ft. Sam Houston, TX.

Garrett, Michael, MAJ, Operations Officer, XVIII ABN Corps. Interviews by author, 6, 9, 23 December 1991 and 21 January 1992, Ft. Bragg, NC.

Gellerman, Saul W. "In Organizations, as in Architecture, Form Follows Function." Organizational Dynamics 18, no. 3 (Winter 1990). New York: American Management Association, 1990.

Kim, Myung H., COL, Commander, 44th Medical Brigade. Interview by author, 6 December 1991, Ft. Bragg, NC.

Kussman, Michael J., Internal Medicine Consultant to the Army Surgeon General, Office of Medical Corps Affairs, 1989-91. Interviews by author, 10 December 1991 and 5 February 1992, Carlisle, PA.

Lombard, James E., LTC. The Echelons Above Division Medical Support Structure to Support the Army in the Field in the 1986-2000 Time Frame. Washington: Defense Logistics Agency, April 1982.

McDonald, Frank G., LTC, Medical Force Integrator J-1, Forces Command. Interview by author, 3 January 1992, Atlanta, GA.

Nelson, , Medical Research and Development Command. Interview by author, 10 February 1992, Frederick, MD.

Pearce, John A. II, and Robinson, Richard B., Jr. Chapter 10: "Fundamentals of Organizing." Management, First Edition. New York, Random House, 1989.

Poux, Robert J., LTC, Force Modernization, Office of the Surgeon

General. Interviews by author, 16 December 1991 and 3-5 February 1992, Washington, DC.

Robertson, George S., LTC, Chief of Staff, 44th Medical Brigade, 1990-1991. Interviews by author, 7-8 November 1991 and 3-5 February 1992, Carlisle, PA.

Romines, Robert B., COL, Assistant Chief, Medical Service Corps Branch, PERSCOM. Interview by author, 10 February 1992, Alexandria, VA.

Terrill, Ray J., LTC, 44th Medical Brigade S-3. Interviews by author, 6 November 1992 and 9, 17, 30 December 1991, Ft. Bragg, NC.

Timboe, Harold K., COL, XVIII ABN Corps Surgeon. Interview by author, 6 December 1991, Ft. Bragg, NC.

_____. Establishing Separate Medical Brigade. Decision briefing to Commander, XVIII ABN Corps, Ft. Bragg, NC, 20 December 1991.

U.S. Department of the Army, Army Science Board. Final Report of the 1985 Summer Study on Manning Implications of Logistics Support for Airland Battle. Washington: October 1985.

U.S. Department of the Army. FM 63-3: Combat Service Support Operations-Corps. Washington: 24 August 1983.

U.S. Department of the Army. FM 63-3J: Combat Service Support Operations-Corps. Washington: 12 August 1985.

U.S. Department of the Army. FM 8-10: Health Service Support in a Theater of Operations. Washington: 1 March 1991.

U.S. Department of the Army. FM 100-5: Operations. Washington: 5 May 1986.

U.S. Department of the Army. FM 100-10: Combat Service Support. Washington: 18 February 1988.

U.S. General Accounting Office. Operation Desert Storm: Full Army Medical Capability Not Achieved. Testimony of Richard Davis, 5 February 1991. GAO/T-NSIAD-92-8.

Zierdt, John G., BG, Commander, 1st COSCOM, 1989-91. Interview by author, 20 December 1991, Atlanta, GA.